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ABSTRACT

This practicum was designed to provide speech and language therapy to children identified as speech and language impaired, in a Head Start classroom with typically developing peers. The practicum involved amending Head Start component plans, discussing inclusion issues at four education component meetings, conducting an interagency meeting with service providers to identify what was and was not working with inclusion and how to overcome the barriers, administering pre-post surveys to Head Start teachers and graduate students in special education, identifying the elimination of segregated therapy space as a barrier to inclusion, facilitating establishment of communication centers in five classrooms, and advocating for the least restrictive environment to the Committee on Preschool Special Education (CPSE). Analysis of the outcomes revealed that systemic change in the delivery of speech and language therapy did occur. Twenty-three children used the communication center for speech therapy in their classroom. Head Start teachers and graduate students exhibited changed attitudes about inclusion. The number of CPSE's recommending therapy in the least restrictive environment went from zero to two. Appendices include profiles of the education staff, an inclusion attitudes/beliefs instrument, a workshop outline, and notes for an inclusion presentation. (Contains approximately 100 references.) (Author/JDD)

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Delivering Speech and Language Therapy to Head Start Children: A Template for Inclusion Through Systemic Change

by

Michele Strobridge

Cluster 43

A Practicum II Report presented to the
Ed.D. Program in Child and Youth Studies
in Partial Fulfillment of the Requirements
for the Degree of Doctor of Education

NOVA UNIVERSITY
1993

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PRACTICUM APPROVAL SHEET

This practicum took place as described.

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This practicum report was submitted by Michele Strobridge under the direction of the advisor listed below. It was submitted to the Ed.D. Program in Child and Youth Studies and approved in partial fulfillment of the requirements for the degree of Doctor of Education at Nova University.

Approved:

December 29, 1993

Date of Final Approval of Report

Joseph F. Gonzalez

Dr. Joseph Gonzalez, Advisor

Dr. Joseph Gonzalez

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This practicum was successfully completed because of the circle of friends that creatively supported the writer. The perseverance required to complete the practicum process was unfailing because there was family unity sustaining the writer. Thank you Brother Calvin.

There was academic support and understanding from the writer's practicum advisor. Thank you Dr. Joseph Gonzalez.

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ABSTRACT

Providing Speech and Language Therapy in Head Start Classrooms: A Template for Inclusion Through Systemic Change. Strobridge, Michele, A., 1993: Practicum Report, Nova University, Ed.D. Program in Child and Youth Studies. Early Childhood/Special Education/Inclusion/Head Start/Social Competence/Systemic Change/Speech and Language Therapy

This practicum was designed to create systemic change in the delivery of speech and language therapy in a Head Start program in order that children identified as speech and language impaired would receive speech therapy in the least restrictive environment, the classroom, with typically developing peers. Issues associated with the implementation of inclusion, planning time; classroom environment; staff development; individual education plans; legislative mandates; and social competence were addressed.

To effect systemic change the writer developed a multifarious approach that included amendment of component plans; addressed inclusion issues at four education component meetings; conducted an interagency meeting with service providers to identify what was and was not working with inclusion and how to overcome the barriers; administered pre and post surveys to Head Start teachers and graduate students in the field of special education; identified the elimination of segregated therapy space as a barrier to inclusion; facilitated establishment of communication centers in six classrooms; and advocated for the least restrictive environment at Committee on Preschool Special Education (CPSE).

Analysis of the outcomes revealed that systemic change in the delivery of speech and language therapy did occur. Twenty-three children use the communication center for speech therapy in their classroom. Head Start teachers and graduate students exhibited changed attitudes about inclusion on post survey results. The number of CPSE's recommending therapy in the least restrictive environment went from zero to two. Component plans were amended to address how speech therapy was to be delivered in classrooms.

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CHAPTER I

INTRODUCTION

Description of Work Setting and Community

The work setting for the writer is a Head Start program, that is currently serving two hundred and twenty-five income eligible three and four year old children and families. Head Start is a federally funded preschool intervention program that provides comprehensive delivery of social services, health, nutrition, parent involvement , and education services as prescribed by the goals and objectives set forth in the national Program Performance Standards, established in 1975 by the United States Department of Health and Human Services, Administration for Children and Families, Head Start Bureau. The Performance Standards were amended in 1984 and in January of 1993 Performance Standards for service delivery to children with disabilities was approved.

As a federally funded program, participants must meet income criteria. Allowance is made for ten percent of the enrollment to be over income based on extenuating circumstances that warrant participation, i.e. a single mother, earning $18,000, with three preschool children, one of whom has a disability. Income eligibility is determined by federal guidelines. In 1992, for example, the federal

guidelines ranged from $13,950 for a family of four to $23,470 for a family of eight.

The writer's Head Start program is located in a rural northeastern county where farming, logging, light industry, and tourism are the primary sources of income. The county is a total of eight hundred and seventy square miles of which 55% is woodland; 32% agriculture; and 13% towns and villages. The largest population center is a township of 11,728. There are eighteen other smaller villages and towns with populations ranging from 240 to 7,561. There are ten school districts. With almost 1,000 miles of roadway, conventional transit services are not feasible. There is no public transportation available, other than individually owned cars and several independent taxis. In the neighboring county a privately owned business that provides training and programming for adults with disabilities also provides transportation for the bi-county area. The average distance between towns in fifteen miles, with the nearest major commercial airport fifty miles from the Head Start center. Physically, the terrain is hilly and winter weather severe. Access to a variety of winter and summer recreational activities, provides seasonal income to the primarily racially homogeneous population. 95% of the population is Caucasian; 1.9% African American; 1.6% Hispanic, 1.0% Native American and .5% Asian. Based on per capita income, the Association of Counties for the state, ranks the writer's county fifty-fifth out of sixty-two.

In order to successfully and competently implement the Performance Standards, the writer's program has a staff of seventy. The staff includes bus drivers, family workers, teachers, home-based visitors, cooks, administrative staff, including coordinators for each component and special projects and a program

director. The minimum requirement for employment is a high school diploma. Lead teachers must have at least an associates degree in early education and all but the most recently hired have the Child Development Associate certification sponsored by the Council for Early Childhood Professional Recognition.

Within this work setting, there are two program options. A center based program for families and children living within the designated transportation area. That area is defined as a distance no greater than twenty-five minutes from the center. A home-based program is offered to those families residing outside the catchment area. For the latter option, children and parents are transported to the center one day a week for three hours of peer group socialization experience and parent activities, including training workshops. Central to the home-based option is a weekly ninety minute home visit. The focus of the visit is the parent and utilization of the home environment as the child's primary arena for learning.

For the center based option, children and parents are transported to one of two centers four days a week for three and a half hours of programming. A typical center based classroom has seventeen children ranging from three to four years of age, two teachers, a part-time classroom aide and parent volunteers. Each of the five classrooms also have one and sometimes two high school students who volunteer two days a week in partial fulfillment for course work.

The program also operates three day care centers. One is located at the local community college and serves infants, toddlers, and the three to five year old children of college students. One is located in the Head Start center and serves infants, toddlers, and preschool children from the community, including referrals from the local Department of Social Services. The third center is a newly

established collaboration with a regional vocational high school. Day care is provided for the infants of high school girls who want to remain in school. A unique feature of this program is a parenting class.

The writer's program, in compliance with national Head Start standards, requires that ten percent of the enrollment are children with disabilities. To determine whether or not a disability is present, either the parent brings a concern to a staff member or staff meet with the parent to discuss a concern. Data supporting staff concern (s) is obtained from classroom observations and results from developmental, speech/language, vision, physical and hearing screenings. Upon mutual agreement that there is a concern, the writer describes the evaluation process to the parent. If there is consensus a referral for assessment is made to the Committee on Preschool Special Education (CPSE) for the school district in which the child resides.

The subsequent sequence of events are prescribed by writer's State Department of Education (SED) and include: 1) written parental agreement for the evaluation; 2) parental selection of evaluator, from a list of SED approved evaluators; 3) parental notification of date and time for evaluation; 4) evaluation is completed; 5) results are informally shared with parent (s); and 6) presence or absences of a disability is determined based on assessment outcomes, SED criteria, input from the parent and Head Start staff and Committee on Preschool Special Education (CPSE) consensus. If it is determined that a disability is present, the CPSE completes Part One of the child's Individual Education Plan (I.E.P.) and prescribes how much therapy will be delivered, i.e. ninety minutes a week in an individual session.

For the home-based option, children with disabilities are usually in a shared program. That is, the child is placed in a preschool special education class for remedial work. The focus of the Head Start home visit then builds on self-esteem and social competence.

Children, with disabilities, in the center based option, participate in all classroom activities. The exception being when a particular intervention has been prescribed. The child is removed from the classroom environment and the therapy takes place in an isolated setting. This occurs most frequently with speech and language therapy when the pull-out model is implemented. The therapist comes into the classroom and takes the child to a separate location where the therapy is individually taught for thirty minutes. At the end of the session, the child is returned to the classroom by the therapist.

The populations involved are: 1) three and four year old Head Start children identified as speech and language impaired; 2) ten classroom teachers and assistants (see Appendix A for Education Staff Profile); 3) three certified and SED approved speech pathologists; and 4) three public school Committees on Preschool Special Education. The mandated composition of the committee includes: a parent of a child with a disability; the evaluator; the county representative, and special educator or psychologist.

Writer's Work Setting and Role

The writer's work setting is a rural, northeastern Head Start program, currently serving two hundred and twenty-five children and families. The program was established in 1967, two years after Head Start became a national program The two facilities, in which programming for parents and children is provided, are

quite different in appearance and size. Both centers are licensed through the State Department of Health to provide services to preschool children, including infants and toddlers.

The smaller of the centers is an old Victorian house. With some modifications, each room is accessible for programming, i.e. offices, classrooms, including separate eating area, parent activity room and kitchen. The backyard serves as the playground.

The larger center sits in a corner of a two acre lot. Originally, the building was a three room school house. When Head Start acquired use of the space there was enough room for the classrooms, parent room and activity room for children during inclimate weather. During the past decade and a half, through federal expansion dollars, this site has doubled classroom and office space and added a library and a large conference room.

The writer is one of six component coordinators whose primary responsibility is to assure that the Head Start Performance Standards are fully implemented according to component specific plans. Coordinators supervise staff and assist with the over-all administration of the program. As Special Education Coordinator, the writer, who has been with the program for seventeen years, works with each component to assure that children with special needs receive the full compliment of Head Start services. This can include, but not be limited to: coordinating the developmental screening effort; 2) attending case conference meetings, a multidisciplinary meeting designed to facilitate exchange of child, family, and classroom information in an effort to help families attain self-sufficiency; 3) assisting parents initiate referrals for diagnostic assessment;

4) attending CPSE meetings; 5) observing and working with children to help parents and teachers identify specific developmental strengths and vulnerabilities; and 6) to the greatest extent possible, implement change to meet the spirit and intent of inclusion, that is, meeting the diverse educational needs of all children, with developmental, in the least restrictive environment.

CHAPTER II

STUDY OF THE PROBLEM

Problem Description

Head Start children identified as speech and language impaired were not receiving speech and language therapy in the least restrictive environment, the classroom, with typically developing peers. Therapies, particularly for speech and language was not included as part of the regular classroom activities. Consistent with what has been considered a traditional approach, children identified as speech and language impaired, received therapy in a separate room designated for speech therapy.

Problem Documentation

Evidence supporting the problem was documented through a variety of sources. The sources included classroom observation, written component plans, physical space designated for therapy, CPSE therapy recommendations and Phase One I.E.P. plans. Review of twenty-seven I.E.P.'s developed by CPSE's, stated speech therapy was to be provided through a pull-out model. Pull-out occurred when the child was taken from the regular classroom environment to receive thirty minutes of direct speech and language therapy for a specific number of times each week. The writer's program provided separate space, apart from classrooms, that was designated specifically for speech therapy. Review of component plans

revealed that delivery of speech and language therapy, through a specific approach had not been addressed.

Causative Analysis

Consideration must be given to the underpinnings that support the current situation and need for systemic change. Traditionally, speech and language therapy had been provided through the pull-out model. Viewed as expedient, the pull-out model has been thought of as an effective way to ameliorate children's expressive and receptive language deficits by classroom teachers as well as speech therapists. This approach, separating the intervention from the child's normal activities is well established in the pedagogy of special education and until recently was reflected in legislation and research outcomes supporting segregated placement. For example, children with moderate to severe problems in speech and language received therapy in a preschool language based special education setting and would then attend Head Start for socialization with non-diagnosed peers. An alternative for children not enrolled in Head Start or a special education program has been to provide speech therapy at a clinic generally associated with a hospital.

The writer's state has one of the lowest rates of least restrictive special education placements in the country. According to Autin, Dentzeri, & McNutt (1992, p.1) the following is known about the writer's state: 1) In 1989-1990 the state placed only 7.12% of the children with disabilities in regular classes. The median percentage of children with disabilities places in regular classes in the other forty-nine states was 37.3%; 2) The state also ranked last among all states in the integrated placement of disabled students in regular classes and resource rooms. Only 43.4% of the state's disabled students received services in these settings.

The cost associated with the delivery of special education can not be ignored. In the writer's state, under the current system, school districts are reimbursed at a higher rate for a student placed in segregated settings than if the student were in a least restrictive setting. While the greater impact has been on school-age children, determination of where to serve preschool children with disabilities has been effected.

Head Start staff lack information regarding legislation and state-of-the-art educational practices related to the integration of direct services. In addition, little or no information has been obtained by teachers regarding the developmental and social benefits of integrated services.

Each of the above mentioned underpinnings has effected and hindered how speech and language therapy has been delivered. Implementation of inclusion in part, hinges on greater understanding of how children with disabilities benefit from and reach their fullest potential through interactions with peers in normalized settings. The inclusion of speech and language therapy through developmentally appropriate practices, in the least restrictive environment with typically developing peers has not been given enough attention.

Relationship of the Problem to the Literature

The cornerstones upon which inclusion has been built can be examined through multiple perspectives. In addition to the developmental and social competence underpinnings, this literature review also includes ecological, legislative and school reform perspectives. While each perspective has defining characteristics, in the final analysis, effective implementation of inclusive education

integrates the salient features of each perspective in a manner that supports the diversity of all children.

Meeting diversity, valuing differences within classroom environments, and providing the greatest opportunity for every child's educational need to be met with developmental appropriateness is the overarching goal of inclusion. Inclusion makes education special for everyone. Educating a child in an environment, i.e. a classroom, where the child would be if there were no disability is the conceptual framework around which inclusion has been established. The practice of inclusion is becoming the preferred intervention for children with disabilities because this approach "enables students to become meaningful and active members of the school, *valued* {writer's emphasis} for their own unique contributions, and fully accepted as members of the class" (Salisbury, 1990 p. 50).

Inclusion, from an ecological perspective, is based on a process that "focuses on the exchanges between the child, the settings in which the child participates, and the significant individuals who interact with the child. The objective is not merely to change or improve the child, but to make the system work." (Hobbs, 1975, p.114). Another underpinning upon which inclusion has been established is the principle of normalization, which maintains that any service provided to individuals with disabilities should be based on circumstances that are as culturally normative as possible (Wolfensberger, 1972).

Changing societal attitudes, legislation, and recognition of the developmental significance during the first five years of life provide additional support for the establishment of inclusion. The political and social environments of earlier decades allowed for and supported public policy that enabled state and

federal governments to respond in unison with those advocating for change in the delivery of services to individuals with disabilities. The evolutionary changes that were emerging support Bronfenbrenner's (1979) thesis that development never takes place in a vacuum and that it is always embedded and expressed through behavior in a particular environmental context. Environmental context, defined here as political, social, and educational climates, is of particular significance because it provides the vehicle through which the current provision of educational services, especially for the preschool community, are delivered. A survey of judicial decisions and federal legislative acts are cited because they provide the basis for special education as we know it today.

Historical legislative precedent for prevailing practices can be traced to the first federal law designed to assist individuals with disabilities that dates back to 1798. The law, passed by the Fifth Congress, authorized a Marine Hospital to provide medical services to sick and disabled Marines (Braddock, 1987). More recent legislative antecedents, upon which the inclusive, integrated approach to the education of children with special needs are based, can be found in thirty-eight years of legislation that began in 1954 with Brown vs Board of Education. In this landmark case, the United States Supreme Court ruled that racially segregated education was intrinsically unequal. The case was based on the premise that racial segregation denies the constitutional rights to equality of opportunity (MacMillian, 1982).

It is necessary to mention two other judicial decisions that helped to establish current legislation supporting delivery of educational services to children with diverse abilities. Wyatt vs Stickney, 1971, was a landmark case because the

outcome was the basis upon which rehabilitation in the least restrictive setting was established. The focus of the case was whether institutionalized mentally retarded children had a constitutional right to treatment. Cutbacks in service were the central issue related to a constitutional right to rehabilitation. The constitutional right to rehabilitation follows from guarantees of due process in the 14th Constitutional Amendment and from the prohibition of cruel and unusual punishment in the 18th Constitutional Amendment (MacMillian, 1982).

In 1972, the Pennsylvania Association for Retarded Children (PARC) vs the Commonwealth of Pennsylvania consent agreement established the right to education for children in Pennsylvania, who were retarded. The agreement specified multifaceted diagnosis; child find; placement in the least restrictive, free, and appropriate setting; periodic evaluations; and development of plans describing the range of programs available from the State Department of Education.

Conditions of the consent agreement became the foundation, in 1975, for Public Law 94-142, the Education for All Handicapped Children Act. This law provided for a free, appropriate public education, in the least restrictive environment to all children with disabilities who are between the ages of five and twenty-one. The law also established the right to due process protection. The ecological transitions that have occurred since the law's passage have resulted in significant increases in funding for special education at all levels of government, better and more training of numerous instructional and administrative personnel and parents, increased support of needed research and development of models for delivery of services, and increased awareness and public acceptance for children with disabilities (Garwood, Fewell & Neisworth, 1988).

Public Law 99-457, the Education of the Handicapped Amendments, was passed by the United States Congress in 1986. The law brought special education and itinerant services to pre-school children, toddlers, infants and their families. Sass-Lehrer & Bodner-Johnson (1989) describe Public Law 99-457 as the missing link to the provision of appropriate services for all special needs from birth to adulthood. Through this legislation service providers, particularly the public sector, have begun to broaden their understanding of development as it applies not only to the child with a disability, but also to that child's family. Bronfenbrenner's ecological model of development becomes of particular significance.

The rights of individuals with disabilities have been further expanded through the passage of two laws. Public Law 101-476 reauthorized and renamed Public Law 94-142. Public Law 101-476, Individuals with Disabilities Education Act (IDEA) expanded services to include transition services and improved services for children and youth with serious emotional disturbances, to mention a few. In essence, related services have been made available to all children with disabilities who require them. This includes speech and language therapy. With the passage of the Americans with Disabilities Act (ADA) civil rights protection, similar to those provided to individuals on the basis of race, sex, national origin, and religion, was extended to individuals with disabilities. This legislation was signed into law in 1990.

Change for individuals with disabilities has not only evolved through legislation. Transforming public schools into more responsive environments has evolved into a national concern. Education reform has become a major challenge

for public schools since 1983 when A Nation At Risk: The Imperative for Education Reform was published. This report, condemning the status of American education, spurred national, state, and local efforts to eradicate the blight that existed in public education. Current restructuring efforts see schools as responsible for ensuring that all students learn (Dennison, et al). This implies that there is a changed mission for teaching, one that goes beyond "covering the curriculum" to one that allows learners of diverse needs to construct their own knowledge and develop their own talents in more effective ways (Darling-Hammond, 1992).

The goal of education has always been to prepare individuals to be contributing members of society. Segregated and homogeneous settings cannot prepare students for integrated, heterogeneous society (Minnesota Inclusive Education Technical Assistance Program, 1991). Education reform, with inclusion as one of the quintessential benchmarks, clearly requires a paradigm shift away from exclusion and isolation. Schools that are restructuring to be inclusive, establish environments where children are not tracked, achievements are broadly defined, learning goals and lessons are individualized, and curriculum is flexible and focused on desired student learning outcomes instead of content coverage (Brown, 1993).

School reform outcomes are consistent with the outcomes of inclusion. Both seek to make schools responsive to all students. Research on the most effective modes of service delivery has revealed that when early intervention services are provided in a setting where children with disabilities are integrated socially and educationally with their typically developing age-mates, the

developmental affects for all children are more positive than in segregated settings (Smith, 1992).

As part of the school reform movement, America 2000 initiated under the Bush administration, challenged public schools to be more accountable for better results. America 2000 has six goals. The first one states, all children will start school ready to learn. One strategy was to encourage schools to offer programs to preschool children. That goal is partially being met. Project Head Start, while established long before this initiative, provides a comprehensive, interdisciplinary program to families living on fixed, low incomes. Head Start is the largest public program to serve children with disabilities in integrated classroom environments. Just as significant and substantial changes for schools lie at the heart of the restructuring movement (Miles & Ekholm, 1991) significant and substantial changes are occurring for children with diverse abilities as education takes place in the least restrictive environment. Educationally, the principle of a least restrictive environment is based on the premise that all children should be educated in a manner that does not inhibit interaction with peers nor employ unusual instructional arrangements.

The least restrictive environment (LRE) calls for a pattern of life as close to the expected norm as possible (Meyen and Lehr, 1980). For the child with a disability, LRE means school experiences that least limits or restricts that child's opportunities to be near and interact with other typical children (Taylor, Biklen, Lehr, & Searle, 1987). Support for inclusion can also be found in the Regular Education Initiative which extends the rights and resources in the Education for the Handicapped Children Act to all students (Skrtic, 1991). Inclusion also seeks to

have more children served within the regular classroom than special education classes (Council for Exceptional Children, 1987). It is suggested by Jenkins, Odom, & Speltz (1989) that the presence of advanced peers may create a more developmentally complex environment, which, if the complexity is not too great, may give the children with disabilities a developmental "push" toward acquiring and practicing advanced skills. The research concluded that interacting with normally developing peers in structured play activities appeared to facilitate the development of social competence for preschool children with diverse ability.

In addition to the legal, philosophical and educational rationales there is one ingredient that makes the least restrictive environment appealing to program administrators and taxpayers. In the long run this program option saves money. Tuition costs are kept at a minimum because teachers, assistants, special education teachers and therapists work in the same room. Through inclusion, of all the expertise is in one classroom.

The concept of inclusion meets the diverse needs of all children, including those with disabilities, within supportive educational environments. The thrust of inclusion, according to Guarlnick (1990a) and Salisbury &Vincent (1990) is toward heterogeneous cooperative learning in unified settings that provide the opportunity for every child's educational needs to be meet with developmental appropriateness. Developmental outcomes are seen by Prizant and Wetherby (1990) as a result of the interrelationships between the child, the caregiver [teacher] and the environment. It is the interaction between the child and natural environment [the classroom] that mark a defining characteristic of inclusion. Inclusion is built on the notion of reciprocity, the interrelationships of the child and classroom

environment. With educational supports, the ecology of the classroom provides the child with a disability greater opportunities for learning and acquisition of social competences than if the child were in a segregated setting.

Salisbury (1990) suggests that inclusion acknowledges the importance of understanding the whole child, the child in context, and the complex interdependencies between learner and the context. This relationship directly and indirectly influence what and how the child learns. Sapon-Shevin (1991) defines inclusion as meeting the educational needs of all children within a common environment. Common environment is defined as the classroom where learning that is developmentally appropriate takes place.

Developmental appropriateness is approached through creation of environments that match a child's age-related ability to choose appropriate experiences. These experiences foster individual initiatives, decision making, making choices, acting independently and in growing toward social competence (Miller, 1992). With inclusion, curriculum and environment are adopted to meet the need(s) of the child. According to Theadore, Maker, & Prizant (1990) to the extent possible, intervention efforts should happen within the context of naturally occurring routine and play situations. The diverse needs of all children are accommodated to the maximum extent possible, within the general education curriculum Bailey & McWilliam (1990); Guralnick (1990b); Salisbury (1986); and Strain (1990). Successful mainstreaming [inclusion] of young children with diverse abilities requires integration of these children in all domains, including the temporal, social, and instructional components of a program (Turnbull & Blacker-Dixon, 1981).

Hanline (1985a) and Jenkins, Odom & Speltz (1989) have concluded that inclusion does not spontaneously occur. Inclusion must be encouraged by teachers who must strive for a positive attitude in order to communicate honestly, openly and knowledgeably about disabilities. One avenue through which greater opportunity to communicate openly about disabilities can occur is teacher preparation course work. The current system of teacher training needs to be reformed. Regular and special education needs to be merged into one approach that implements the best of both disciplines.

Peck, et al (1989) found that regular and special education teachers had mutual concern centered on program goals and philosophy when inclusion was implemented. Leyser and Abrams (1986) discuss teacher preparation and report that among other concerns, practicing teachers identified the need for more training about the rationale for mainstreaming, classroom management, and assisting students understanding of individual differences. In a post secondary school of education survey, Kearney & Durand (1992) found that in New York State there was insufficient course work and field experience to prepare general education preservice teachers for inclusion classroom settings.

To supplement teaching and environmental strategies, there is support in the literature that suggest parents of children with disabilities favor inclusion. Hanline (1990b) states that with inclusion, parents can be less isolated and have more opportunities to be normally involved with their child's education. Margolis and Tewel (1990) stress adherence to the concept of least restrictive environment. Integrated classrooms can increase trust, improve relationships, and enhance cooperation with all parents and particularly with Black and Hispanic parents.

whose children have traditionally been over represented in special education classrooms.

Close communication between home and school is cited by Honig (1979) as an approach that helps both teachers and parents learn more about the child's development. Bundy (1991) has identified pre and post enrollment communication techniques between parent and teacher. Home visits, phone calls, individual notebooks and regular conferences are specific activities that are cited.

McLean and Hanline (1990) broaden the process of communication to include special educators, paraprofessionals, and therapists so that successful, integrated service delivery will be accomplished within the context of on-going developmentally appropriate learning activities. Head Start programs have been identified as an integrated opportunity for preschool children with disabilities. The comprehensive intervention approach with emphasis on parent involvement, in particular, has established Head Start as a model that provides a natural fit for inclusion. School districts are encouraged to collaborate with Head Start in expanding integrated opportunities for children with disabilities (Newsbriefs, 1991).

Dodge and Grimm (1992) suggest classroom collaboration where the therapist and teacher work cooperatively within a common environment helps to create an infrastructure that supports inclusion. Paul-Brown (1992) and Coufal, Steckelberg & Vasa (1991) state that communication is not a separate, isolated subject that can be taught in a vacuum. The authors suggest that services should be: 1) coordinated with family members, clients, and other professionals;

2) conducted in the actual settings where communication occurs; 3) meaningful and relevant; and 4) involve regular conversational partners.

One of the major developmental tasks of the preschool years is to acquire social interaction skills and use them in a socially competent manner with peers Head Start Performance Standards (1984); Odom, Peterson, McConnell and Ostrosky (1990); Burstein (1986); Guralnick and Groom (1988); and Sainato (1990). Social competence is defined by Guarlnick (1990b) as the ability of young children to successfully and appropriately select and carry out their interpersonal goals.

Sainato & Carta (1992) discuss the preschool classroom as one of the primary environments in which young children with disabilities are provided the opportunity to interact with peers in a variety of situations. Among the influences considered are classroom activities; activity structure; group composition; age of peers and spatial variables. Haring (1992) concludes that to build social competence there must be: 1) understanding social competence as a dynamic relation within both situational and motivational contexts; 2) understanding social competence within the context of building human relationships and social networks; and 3) appreciating the developmental necessity of generalization in building social competence.

The research outcomes of Odom, Peterson, McConnell and Ostrosky (1990) suggest that early education classrooms may provide more facilitative contexts for promoting social interactions skill development for young children with disabilities than specialized classrooms. The researchers found that in early education classrooms, children spent a proportionally greater amount of their time

in verbal interaction with their peers than children in specialized [segregated] settings. In fact, curricula, in specialized classes, appear to be more didactic in nature as the teacher directs the activities (Anastasiow, 1978).

It is significant to note the findings in a follow-up study of school-age placement assessing early intervention. Miller, et.al. (1993) found that children from segregated preschool settings were twice as likely to retain special education eligibility in kindergarten than their mainstream counterparts. The children were also at least three times more likely to receive services in segregated settings. In the second year follow-up of the segregated group, 89% retained or regained special education eligibility as compared to a stable 37% of the original preschool mainstream group. In terms of placement, service delivery in segregated settings was four times more frequent for the preschool segregated group than for the mainstream group.

Wishon (1982) has identified six imperatives that can be used to guide successful inclusion of children with special needs. The imperatives are: 1) recognize the individual's potential; 2) affirm the importance of early intervention; 3) emphasize prevention; 4) maintain family integrity; 5) underscore the worth and dignity of the individual; and 6) provide comprehensive services. A seventh imperative could be added, educate in the least restrictive environment.

Speech-language specialists should teach children who are delayed in language development through involvement in naturally occurring conversation rather than through remediation drills (Garrard, 1987). While the results were tentative, Bain, Olswang, and Johnson (1992) conclude that imposed structure and familiarity with materials is not as effective as providing enough interesting

materials to ensure opportunities will arise for language behaviors of interest, as would be the situation in a classroom environment. Hoff-Ginsberg (1985) suggest that language acquisition is dependent on a variety of environmental supports and therefore language development is grounded in an interactionist perspective.

Lieven (1984) suggests that the directive [or didactic style] provides the child with minimal opportunity for immediate connection with spoken language. The author states that when children are removed from their familiar contexts, such as home or classroom, in order to be helped with their language learning, they may be unable to exhibit their most creative uses of language because the pull-out approach is not child centered. This disequilibrium, if you will, can interrupt situations where the acquisition of language would be facilitated naturally. It is not uncommon to hear, "Why does she always have to go out when I want to play with her?" The absence of positive interaction skills predicts peer rejection and ridicule (Strain, Keer, & Ragland, 1981).

Speech and language therapy provided in classrooms is supported by Perlmutter, et al (1981) whose research indicate, at least experimentally, that increased integration of target and context items also increased the salience of context for children. Integrated speech and language therapy is further supported by developmental research that indicate semantic cues almost always facilitated recall, particularly for children three to five years of age. While it is not yet a universally implemented practice, Westlby (1990) reports that since the 1970's when wider interest in pragmatics was established, speech-language pathologists have sought to develop language treatment programs for children that integrate the use of pragmatic, semantic, and syntactic knowledge in naturalistic communicative

settings with peers and adults. The language learning of the child's natural environments, i.e. classrooms, could then become the treatment program.

Pellegrini and Galda (1990) conclude that if we want children to use desired forms of language, such as elaborated noun phrases, the best way of doing it is to put children into contexts that will elicit such form of language. Inclusive speech and language therapy is equally important from both behavioral and developmental perspectives because a primary focus is successful communication, not on language per se (Warren and Kaiser, 1988).

Huefner (1988) has identified potential benefits that an integrated model, with a consulting therapist could yield. The benefits include, but are not limited to: 1) reduction of stigma [to the child]; 2) better understanding across disciplines; on-the-job training for regular educators in special education skills; and 4) spillover benefits to regular students. Some tentative dangers include: 1) inadequate support from regular educators; 2) inadequate funding mechanisms; and 3) converting the model to tutoring or aide model. Wolery (1991) states that while specialization begets fragmentation, collaboration, when accompanied with willingness to learn and availability of persons with whom to collaborate, provides the structure for solutions. The divisions, that were once considered requisite for optimum learning are now viewed as roadblocks, particularly for inclusion.

Fleming, et al (1991) analyzed preschool teacher's behavior in order to identify how to embed effective instructional strategies in on-going practices with children with disabilities. Consideration is given to: 1) adaptations of roles rather than adaptations of activities; 2) different adaptations may be needed for each role

the teacher plays; and 3) adaptations must account for the fluid movement from role to role.

Of critical concern in the effective implementation of Public Law 99-457, is the availability of qualified professionals to provide services to young children with disabilities and their families (Stayton & Johnson, 1990). Personnel shortages for both the birth to three and three to six population, with continued shortages into the next decade is reported by Meisels, Harbin, Modigliani and Olson (1988).

The time is right for universities to merge the best practices of early childhood education with the best practices of early childhood special education into personnel preparation programs for teachers of all young children. Carta, et al (1991) in highlighting the commonalties and differences between early childhood special education and developmentally appropriate practices, conclude that special instruction - instruction that is effective, efficient, functional, and normalizing - can be delivered in integrated settings.

Within early childhood special education, models of intervention share a common goal that is not in opposition to developmentally appropriate practices. The goal is "to prevent or ameliorate the effects of a handicapping condition or problems that have a high probability of manifesting themselves as developmental or school related difficulties (Linder, 1983, p.1). Some of the basic premises for developmentally appropriate practices and early childhood special education, in fact share a common understanding about how young children learn. Both approaches agree: 1) that curricula must be broad enough to include children with varying interests and skill levels; 2) with the concept of individualization; 3) about the importance of identifying naturalistic opportunities for instruction and using

child-initiated activities for implementing instructional interactions; and 4) that children learn best in programs that promote active involvement of parents (Carta, et al, 1991). Taylor (1988) stressed that the need is *not* {writer's emphasis}for specialized settings but for specialized teaching and that integration should not be confused with services that are less intense.

Miller (1992) contends that fractionalization in teacher education programs is contradictory to all legal, philosophical, empirical, economic, and moral reasoning for early childhood education. Such segregation practices in teacher training perpetuate the myth that particular types of children need teachers who have been trained in discrete bodies of knowledge and pedagogy accessible only to members of specialized fields of expertise. The author maintains that teachers must be prepared to meet children's needs along a broad continuum of development. Without unification of early childhood special education and early childhood education, the least restrictive environment and community integration goals of special education will be elusive and early childhood programs stand a high chance of being restrictive for all young children and their families (Burton, et al, 1992).

Establishing inclusive classrooms is not without barriers. While the underlying tenets are based on similar premises, it appears that changing service delivery is not easy. Strain and Smith (1991) have identified global educational and social contexts that are perceived barriers. The roadblocks are: 1) educational reform and the need to compete in world markets are philosophically and operationally intolerant of integration; 2) unionization of educational professionals and protectionism of the same; 3) site-based management allows for greater variance in integration practice, or lack of it; 4) expanded role of parents in

schooling, a practice not limited to the special services area; and 5) unprecedented fiscal problems. While it appears that the least restrictive placement is less costly than segregated special education settings, Jones (1991) cautions that placement choices for children with differing abilities must follow the requirements of Part B of the Individual with Disabilities Education Act, formally known as Public Law 94-142.

Inclusion offers the best education approach for children with disabilities as long as the barriers are creatively overcome. "It must be remembered that there is nothing more difficult to plan, more doubtful of success, nor more dangerous to manage than the creation of a new system. For the initiator has the enmity of all who would profit by the preservation of the old institutions and merely lukewarm defenders in those who could gain by the new ones." (Machiavelli, 1513).

The literature reflects other approaches for implementating inclusion. Peer-mediated-teaching classmates to serve as intervention agents has been suggested by Odom, Hayson, Jamieson, and Strain (1985) to be effective when working with children identified as speech and language impaired. Script training in which children are taught the script through a process of prompting and fading was found by Goldstein and Gallegher (1992) to impose an expectation for interaction and communication among children.

Eiserman, McCoun and Escobar (1990) suggest that with appropriate training and on-going assistance, trained mothers can provide therapy for speech correction, language acquisition and general development to their children who are moderately speech-disordered. Warren and Gazdog (1990) conclude that milieu intervention procedures, i.e. integrating incidental teaching, mand-model, and

systematic commenting procedures can be used to enhance the acquisition and generative language use.

Large group instruction, utilizing direct instruction, interactive and incidental teaching is, according to Seifert and Schwarz (1991), a viable option for Head Start children vulnerable to language and basic concept acquisition. Peck, Killen, and Baumgart (1989) have proposed the use of a nondirective consultation strategy for increasing implementation of instruction for preschool children who receive educational support services in the classroom environment.

There is a growing body of literature and empirical evidence to support inclusion. The practice of inclusion represents the best of two worlds, regular and special education working together in common environments for all children and families. The convergence of legislation and research outcomes have established that when education is provided in inclusive settings, positive change occurs. Prestine & Bowen (1993) note that change, as a noun and verb, is both substance and process. That as such, means cannot readily be separated from ends. So too with inclusion. The process of inclusion is tied to the substance. It is this interaction, when provided in the least restrictive environment, that produces education equally special for all children.

This practicum sought to effect systemic change in the delivery of speech therapy. It was intended that moving from a pull-out model to an inclusion model would reduce the number of recommendations for placement in segregated setting; eliminate separate program space designated for speech therapy; increase communication between classroom staff and speech therapists; and above all, create

classroom environments where active learning is accessible to each child, regardless of the range of ability.

CHAPTER III

ANTICIPATED OUTCOMES AND EVALUATION INSTRUMENTS

Goals and Expectations

The goal of the practicum was to effect systemic change in the delivery of intervention services for children with disabilities, particularly children identified as speech and language impaired. It was anticipated that Head Start children, identified as speech and language impaired, would receive speech and language therapy in the least restrictive environment, the classroom, through educational practices consistent with typically developing peers.

Expected Outcomes

It was expected, that through systemic change in the delivery of intervention services for children identified as speech and language impaired, the following outcomes would have occurred: 1) children would receive speech and language therapy in classroom settings through activities with normally developing peers; 2) ten teachers would identify at least three defining characteristics of inclusion; 3) teachers and speech therapists would arrange regularly scheduled time to discuss activity plans and children's progress; 4) areas used for speech and language therapy would have been disassembled and used for other program activities; 5) Individual Education Plans of children identified as speech and language impaired would recommend that therapy be provided through educational practices consistent

with typically developing peers; 6) the number of Committees on Preschool Special Education to recommend that speech therapy be provided in an environment that was not isolated from other children, would increase from zero to three; and 7) five Head Start component plans would reflect how delivery of speech therapy was to be accomplished in classrooms.

Measurement of Outcomes

Evaluation criteria of the expected outcomes was measured by the systemic changes that occurred in the delivery of speech and language services to children enrolled in Head Start. Systemic change was defined as I.E.P.recommendations for speech and language therapy to occur within the classroom environment; implementation of regularly scheduled time for cooperative planning with teachers and speech therapists; revised Head Start component plans to address inclusionary practices; the designation of the existing therapy room for other program use; and teacher identification of at least three characteristics that define inclusion. To broaden the scope of implementation and address inclusion related issues, a workshop presented by the writer for a regional Head Start conference on disabilities and a college lecture on inclusion to special education graduate students were two strategies used to indicate the diverse populations affected by inclusion.

To obtain self appraisal on a common set of attributes or values assigned to inclusion, a Likert Scale was used (see Appendix B for Likert Scale). There were fifteen statements that required Head Start teachers and special education graduate students to rate or evaluate each statement quantitatively on a scale of one to five. The range of numbers represented levels of agreement or disagreement with each statement. The Likert Scale on inclusion was used before and after implementation.

Based on the following conditions the writer assumed the integrity of the responses to be accurate: 1) rater anonymity and 2) the topic was one currently affecting either the work place or the preparation for certification. Itemized responses from the Likert Scales were summarized through the mean score of each statement. Pre and post implementation results were used to indicate whether or not inclusion was supported.

Additional analysis of systemic change was accomplished by identifying the number of children moved from a pull-out approach to an inclusion model. I.E.P.'s were reviewed to identify the number of recommendations for direct therapy in the classroom. Changes in the use of existing space for speech therapy would be described. A journal of practicum activities was maintained. The journal documented unexpected events that enhanced or hindered practicum goals and objectives.

CHAPTER IV

SOLUTION STRATEGY

Discussion and Evaluation of Solutions

The problem presented in this practicum was that preschool Head Start children identified as speech and language impaired were not receiving speech and language therapy in the least restrictive environment with typically developing peers. Evidence supporting the delivery of speech therapy through the pull-out model was documented through classroom observation, written component plans, physical space designated for therapy, CPSE recommendations and Phase One I.E.P. plans. Assessment of the situation lead to the tentative conclusion that Head Start children identified speech impaired were not receiving intervention services consistent with the social and developmental benefits of normal classroom activities with typically developing peers, in the least restrictive environment.

A review of the literature suggested several possible solutions. McLean and Hanline (1990) suggest that integrated service delivery could be accomplished within the context of on-going developmentally appropriate learning activities. Inclusion supports and is consistent with Piagetian developmental theory. For when activities are carried out in a social context it is possible for a child to be involved in experiences which produce the optimal degree of cognitive disequilibrium and hence the impetus for cognitive restructuring (Hohman, Bante,

& Weikart, 1973, p.3). The inclusive environment, that is developmentally appropriate to begin with, is able to support what is happening or contemporary for the child. This is particularly critical for the preoperational child who is egocentric and interested in meeting immediate needs.

Facilitating meaningful communication in a social context requires that the interaction be conducted in an environment that is less structured and less teacher directed (Muma, 1978). Within that context, greater opportunity is provided for social competence to emerge. Sainato (1990) has suggested that peer-mediated interventions may prove to be an effective means of promoting independent performance [and therefore social competence] particularly during transition times.

Classroom collaboration, where the therapist and teacher work cooperatively within the common environment is stressed by Dodge and Grimm (1992) as a major support in making inclusion a successful experience for everyone involved. Through team teaching and the combined experience of support staff the diverse needs of all children stand a greater chance of being met (Deno, Maruyana, Espin, & Cohen, 1990). Wolery (1991) suggests that successful collaboration requires, at a minimum, program's willingness and access to planning time in order to make inclusion successful.

Classroom collaboration involving multiple disciplines provides an informal forum for staff development. Wang, Vaughn, & Dytman (1983) note that staff development efforts that address day to day implementation problems facilitate the restructuring of regular classrooms to accommodate special needs students. Hanline's (1990) discussion of the consulting teacher [therapist] model provides support for inclusion. Staff training, parent involvement and identification of

services and support to the child and teacher are components that make inclusion successful. Additional support, needed to make inclusion successful, is collaboration among regular education and special education personnel (Lilly, 1986; Miller, et al, 1993; Smith, Salisbury, & Rose, 1992; and West & Cannon, 1987).

Expanding support for inclusion Bundy (1991) identified pre and post enrollment communication techniques between parent and teacher as an activity that could help foster inclusion. This practice is consistent with the Head Start philosophy of involving parents in all aspects of the program. Adaptions of instructional behaviors notes Fleming, et al (1991) should be matched to teacher's current practices, rather than requiring new and different teaching styles and activities. This is consistent with the solution strategy of incorporating speech and language therapy into classroom routines and activities.

In addition to curriculum content and individualized learning, creating systemic change must also consider the following composit of characteristics for successful inclusion: 1) administrative and professional commitment for inclusion; 2) adequate supports for teachers and on-going commitment to professional development; 3) emphasis on collaborative decision making between personnel trained in "special" and "regular" education; and 4) provision for overall program evaluations including the opinions of consumers (Salisbury, 1990).

Description Of Selected Solution

Through ideas gleaned from the literature and designed to respond to the needs of the work setting, the thrust of the solution strategy was systemic change in the delivery of speech and language therapy. Given the diverse components that effect and impact successful inclusion the design of the solution strategy was based

on change in multiple arenas. The approach was multifaceted and composed three phases. It was anticipated that through systemic change, children identified as speech and language impaired would receive therapy in the least restrictive environment with typically developing peers.

Activities of the solution strategy that were attempted included: 1) children would receive speech and language therapy in classroom settings through activities with typically developing peers; 2) identification of at least three characteristics that define inclusion through teacher training in educational practices and legislative mandates that support and promote integrated therapy; 3) teachers and speech therapists would arrange time to discuss children's progress and implementation of inclusion; 4) the existing separate space used for speech therapy was designated for activities other than speech therapy; 5) when attending Committee on Preschool Special Education meetings, with writer advocated for the IEP to state that speech and language therapy be delivered in the least restrictive environment; 6) the number of Committees on Preschool Special Education to recommend that speech therapy be provided in an environment not isolated from other children increased from zero to three; and 7) written component plans were amended to reflect implementation of related services within classroom environments.

Other solution strategies activities that were completed by the writer were: 1) attended a national conference focused on inclusion; 2) conducted a workshop on inclusion for a regional Head Start disabilities conference; 3) established a section of the program's library focused on inclusion; 4) the writer obtained permission from a local college to lecture on inclusion for special education graduate students; and 5) the writer initiated contact with the preschool special

education director to establish a working group that explored establishing a collaborative classroom.

Driving the success of the practicum was the commitment and ability of the writer's program to provide a developmentally appropriate program to all children. In addition to ability and commitment, the underpinnings that supported inclusion were found in empirical research and the American's With Disabilities Act that established the right to equal opportunity for children with disabilities to participate and receive the full benefit of a program in integrated settings. Furthermore, the writer's State Department of Education has recently mandated that integrated services become a viable program option at the preschool level.

Prior to implementation, the outline was shared with program coordinators and the director. Deadlines and financial commitment necessitated several strategic preliminary activities. These included permission to conduct a workshop for the regional Head Start conference on disabilities and to attend a national conference on inclusion.

During implementation, the writer had lead responsibility for all of the activities detailed. As a result it was anticipated, that the writer's skills and abilities, particularly as related to advocacy, would be strengthened. It is significant to note that this Head Start program views the practicum process as training for everyone involved and supported the writer's development through implementation. From it's inception one of Head Start's primary objectives has been to establish environments and provide experiences through which children build on their skills to acquire greater social competence. This programmatic

variable, coupled with the commitment to staff development created an atmosphere where systemic change was viewed as positive.

While empirical evidence, legislation, and best practices support inclusion, there was one external variable that influenced implementation. Working with professionals representing a range of disciplines that value inclusion from different perspectives, the writer was not always able to complete activities in a timely manner. The creation of change was not viewed by all the stakeholders with the same degree of urgency.

Report of Action Taken

Through the selected solution, systemic change in the delivery of speech therapy occurred. Children identified as speech and language impaired were no longer pulled-out, removed from the classroom for therapy. Over a period of eight months, the solution strategies followed a developmental progression. There were three phases in which distinct and discrete activities occurred. Each phase was slightly more than two and a half months in duration. The outcome (s) of each phase were incorporated into the subsequent phase. Throughout each phase there were on-going, work related activities that were conduits for particular aspects of the solution strategies. These activities were: 1) monthly education staff meetings and 2) Committee on Preschool Special Education meetings. Through these forums, the writer accomplished several solution objectives.

During four of the six staff meetings, the writer presented information about inclusion, through legislative and developmental perspectives with emphasis on social competence. Content for this information was obtained through the literature review, the writer's visits to model inclusion preschool programs, and information

gleaned from the national conference on inclusion. Throughout the entire implementation these meetings were used to discuss whatever concerns and successes teachers were experiencing through systemic changes. Brainstorming was the technique used to identify the problems with and solutions for greater success with inclusion.

It was during the first staff meeting after implementation began that ten teachers completed the first values clarification exercise. The second values clarification exercise occurred during the staff meeting of the final month of implementation. To indicate participation the second time, staff wrote the numeral two at the top of the page. New staff wrote the numeral one at the top of the page. The same instrument was used each time. A comparison of results was made to determine whether or not greater support for inclusion had been established.

A second conduit through which systemic change occurred was CPSE meetings where support services and level of intervention was determined. The governance of these committees is determined by federal and state law. It was from within that framework that decisions were made. The writer attended CPSE meetings either at the request of the parent or committee chairperson. Upon review of standardized assessment outcomes and the child's need, obtained through classroom performance as represented by the writer and child's teacher, the committee determined, based on state criteria, whether or not a disability was present. When a diagnosis of speech and language impairment was determined the amount and type of services was designated. At this juncture, the writer advocated for therapy to be delivered in the least restrictive environment with the child's

normally developing peers. When integrated therapy was not recommended, the child received therapy in a separate and segregated program.

Midway through Phase One, the writer's program received notice to begin implementation of a five year training grant. The grant, by design and size, became a major undertaking. On the heels of this award, a community church "gave" an old school and rectory to the program. Until the rectory could be refurbished, the Head Start center had to accommodate new staff. Conversion of the speech therapy room occurred much sooner than anticipated and without adequate lead-in and planning time. In fact, it literally happened over night. For the remainder of the year, four months, speech therapy happened wherever it could, hallways, a multipurpose room, in classrooms, and occasionally in someone's office. Over the summer, the grants people moved into the rectory. Two home-based visitors moved into the vacated speech office.

To render the impact of this sequence of events positive, the writer met with education staff and brainstormed what was working, what did not and how problems could be solved, vis-a-vis, speech therapy. The writer also initiated a meeting with the Service Coordinator supervising the on-site speech therapists to discuss issues related to delivery of speech therapy.

While the roadblocks that occurred were difficult to manage at the time, the detours provided opportunities for challenging solutions. As with the noun-verb analogy mentioned earlier, the process of implementing systemic change is an interactive and interdependent process where the means cannot be readily separated from the ends (Prestline & Bowen, 1993).

Phase One of implementation was fact finding and preparation. The writer's knowledge base of inclusion was expanded through site visits to several preschool programs that provide programming to all students, regardless of disability. The focus of the site visits was to find out how inclusion was implemented and to identify the key elements to consider or avoid. From the literature review and site visits, the writer was able to prepare outlines for the Head Start conference and college presentation.

Phase Two of implementation began with the writer attending a week long, national conference on inclusion. Recognized leaders in the field examined integration and inclusion issues and practices for children, birth to six (see Appendix C, National Presentors). The conference also provided a rich forum for the exchange of ideas and national networking.

The next major activity of the second phase was the writer's two hour presentation at a regional Head Start conference on disabilities. The two day training is an annual event coordinated by the Resource Access Project (RAP). Each of the ten Head Start regions in the nation has a RAP, whose primary function is a clearinghouse of information on disabilities to Head Start programs in the respective regions. The target audience for the presentation was parents. The how's and why's of inclusion were viewed through historical and legislative lens of special education from 1954 to the present. The writer examined why inclusion rather than segregated settings helps children obtain greater social competence (see Appendix D for Head Start conference outline).

By the end of Phase Two the writer had written the college presentation and prepared materials. Throughout the preparation, the professor with whom the

writer was working was appraised of content and delivery of presentation (see Appendix E for Inclusion Presentation).

The focus of the presentation was changing the special education paradigm through inclusion. At the beginning of the morning students completed a values clarification survey by indicating responses with a circle. This survey was the same one completed by Head Start staff. Philosophical, ethical, legal, values, historical and empirical perspectives were considered. Changes in the delivery of services including education were graphically represented by a ladder, the lock step approach and a lattice, which allows for and supports change in multiple directions (Bredekamp & Willer (1992). Developmental underpinnings of inclusion were examined through social, physical, and instructional domains. Particular attention was paid to the area of instruction because it appears to have to most barriers, i.e. turf; fear based on a lack of knowledge; control; and training.

Using an undocumented conference handout, the writer summarized the presentation by looking at a set of elements in managing complex change. When each of the five elements, vision, skills, incentives, resources, and action plan are present change occurs. Outcomes differ depending on which element is missing. For example, if there was vision, skills, incentives and action plan, but no resources (planning time, support staff) frustration is the outcome.

Two activities concluded the presentation. Students repeated the values clarification activity by putting a square around the response. When summarizing the responses the writer was able to identify, albeit tentative, changes in attitude related to inclusion. The writer challenged students to solve a five piece puzzle in

which the inclusion piece touches each of the remaining pieces, family, child, supports, and school.

Phase Three of implementation began with the writer amending those sections of the health, social services, parent involvement, education and nutrition component plans as prescribed in the Head Start Performance Standards. Every change that was made reflected how children with diverse abilities were included in all aspects of the program. For example, Goal 1304.3-3b[9] states: To provide services for children with speech impairments and/or delay language development. The writer amended implementation of this goal to reflect that speech and language therapy would be delivered in the least restrictive environment with typically developing peers. Throughout each plan the word mainstreamed was changed to inclusion and inclusionary, depending on the particular context. The words diverse abilities and differing abilities replaced the words handicapped and disability. In an effort to deemphasis a division between regular and special education, the writer's job title was changed from Special Education Coordinator to Associate Education Coordinator.

The writer initiated a meeting with the administrator of the agency for whom the speech therapist worked. The purpose was to discuss inclusion and delivery of speech therapy within the classroom. The outcome was an interagency meeting with Head Start teachers, the writer, speech therapist, and program administrator.

At the meeting, the writer described the long standing relationship between both agencies and the range of services that have been provided. Everyone agreed that change from pull-out to inclusive, integrated services was the best approach and that therapy, wherever there was room was not effective for anyone involved.

Other identified problems included: 1) no mutual planning time for teachers and speech therapists; 2) not enough contact with parents; and 3) random time for speech therapy. It was unanimous that change was not easy but definitely necessary.

The question became, what would speech therapy look like if pull-out was not an option. The outcome was that each room would develop a communication center that would function like other learning centers in the rooms, i.e. family, art, and block areas. The communication area would incorporate existing materials into one location. The center would have books, pencils, activity cards, crayons, paper, books, telephones, tape recorders, picture cards, computer, a small table and several chairs. The area could be used by all children. It was felt that by designating an area for speech therapy in the room, other children would be able to observe what was going on and could also join the activity if desired, just as they do with all of the other activities.

Three other concerns associated with successful implementation of speech therapy in the least restrictive environment were addressed. It was mutually agreed that: 1) regularly scheduled planning time for teachers and therapists was necessary; 2) parents needed to be regularly informed; and 3) in-service training, provided by the speech therapist would enhance teacher's awareness of and ability to incorporate, through classroom activities, strategies for speech and language skill building and workshops related to language and speech development be offered to parents.

The final activity of Phase Three for the writer, other than synthesis of the practicum process and outcomes, was meeting with the education staff to assess

responses to changes in the delivery of speech and language therapy. Again, the technique of brainstorming was employed because all comments are freely considered. Based on such comments as, "I have more information." "The children do not have a difficult time becoming engaged with peers after spending time with the therapist." and "We like the planning time on Mondays, it gives us some ideas for activities that support what the therapist is doing." "Communication center time conflicts with our outside time.", the writer concluded that, overall the changes in the delivery of speech and language therapy have been positive and that there were some glitches remaining to be worked out.

It was at this point that teachers repeated the values clarification activity that had been administered during Phase One. The writer then compared and contrasted the results to determine whether or not any value change had occurred.

Throughout the entire implementation period, the writer's program had been preparing to increase the number of children and families served. This expansion effort included establishment of a third center and meant an additional thirty-four children and families. Impact on practicum outcomes was limited to three new teachers who had not participated in any implementation activities other than the second values clarification exercise. It was anticipated that children identified as speech and language impaired by the CPSE in the new catchment area would receive the full benefit of the practicum outcomes.

CHAPTER V

RESULTS, DISCUSSION, AND RECOMMENDATIONS

Results

The problem presented in this practicum was that preschool Head Start children identified as speech and language impaired were not receiving speech and language therapy in the least restrictive environment with typically developing peers. The solution strategy was designed to create systemic change in the delivery of intervention services, and in particular for children identified as speech and language impaired. The following outcomes are indicative of systemic changes that occurred.

Outcome One: Children would receive speech and language therapy in classroom settings through activities with normally developing peers.

Five Head Start classrooms established communication centers. The centers function just like any other learning center. Specific materials were incorporated into the communication centers, i.e. books, pencils, activity cards, crayons, paper, telephones, tape recorders, picture cards, computer, a small table and chairs. The area was open to all children. When the speech therapist worked with a child, the communication center was used. Other children joined in the activity if desired. Through the establishment of communication centers, children identified as speech and language impaired were no longer pull-out of the room for therapy. The

therapist also had access to each of the additional learning centers, the family area and block area for example. The new expansion classroom established a communication center that will be available to the speech therapist when the CPSE identifies children as speech and language impaired.

Outcome Two: Ten teachers would identify at least three defining characteristics of inclusion.

To manage complex, systemic change without vision can leave stakeholders with a sense of confusion. In an effort to avoid this confusion, during four of the six education component meetings, teachers received training in educational practices and legislative mandates that support inclusion. Two value clarification activities, completed at the beginning and the end of implementation lead to the conclusion that teachers in the writer's program have an understanding of and support implementation of inclusion.

The data in Table 1, Summary of Outcomes reflect item by item outcome of the teachers value clarification exercise. The average of the two responses was determined and indicated agreement or disagreement with each statement. Agreement with items 1,2,3,13, and 15 indicated teachers identified characteristics that define inclusion. Disagreement with items 6,9,10,11, and 14 also indicated teachers identified characteristics that define inclusion.

Table 1

Summary of Outcomes

	Agree	Disagree
1. All programs, serving young children should be designed to include all children (children with differing abilities).	11	1
2. It is essential for all children to be socially competent.	10	2
3. Activities designed for typical children are often not appropriate for infants and young children with differing abilities.	8	4
4. All children have the same developmental needs.	4	8
5. I know about the federal and state laws related to special education.	5	7
6. Caregivers and service providers who do not have a background in special education can effectively work with infants and young children with differing abilities.	4	8
7. Children with mild disabilities are the best candidates for inclusion programs.	5	7
8. Young children with differing abilities can learn many important skills from each other.	12	0
9. The individual needs of infants and young children with differing abilities are best met within specialized programs designed for children with differing abilities.	3	9
10. I have less classroom control when therapists are part of the team.	1	11
11. It often seems easier to manage the room when a child pulled out for therapy.	0	12
12. There needs to more laws in order to make education accessible to all children.	7	5
13. The needs of children with moderate and severe differing abilities can be effectively met within an inclusion setting.	7	5
14. Adapting activities to include infants and young children with differing abilities should not be the responsibility of caregivers and service providers trained to work with typical children.	1	11
15. I have a lot of tolerance for modifying program routine and the classroom environments in order to meet the developmental needs of all children.	10	2

Outcome Three: Teachers and speech therapists would arrange regularly scheduled time to discuss activity plans and children's progress.

As a result of the staff meeting with Head Start teachers and speech therapists, it was determined that to improve the quality of speech therapy in classrooms, greater opportunity for planning and training for parents and staff had to occur. Five of the six teaching teams scheduled specific planning time every Monday, the preparation day for staff. At the time the report was written the sixth team, located in the new center did not yet have children identified as speech and language impaired. However planning time had been established.

Each Monday, at the agreed time, the speech therapist planned with individual teaching teams. Time was used to: 1) review children's progress; 2) identify activities that can be used by both teachers and therapists; 3) make sure that communication centers had all the materials necessary for the week; and 4) communicate with one another what has worked and what needed adjustment, i.e. adjust class routine so that going outside does not conflict with speech therapist.

It was also agreed that the speech therapist would accompany teachers on home visits at least three times a year. The therapist would also be available if parents wanted to discuss a particular problem. While no specific topic or time was established, the speech therapist agreed to do in-service training and parent workshops.

Outcome Four: Areas used for speech and language therapy disassembled and used for other program activities.

The goal of this outcome was accomplished through events not directly associated with the practicum. When the writer's program was awarded a five year training grant, office space was needed immediately. The speech therapy room was converted to office space within short order. The advantage was that speech therapy had to continue. The disadvantage was an action plan had not been considered when the grant application was submitted and the false start made inclusion less appealing. The outcome however, was successful in that teachers and therapist realized that inclusion was manageable. Critic of the initial experience generated the realization that without adequate resources implementation of inclusion created frustration.

Outcome Five: Individual Education Plans of children identified as speech and language impaired would recommend that therapy be provided through educational practices consistent with typically developing peers.

As a result of CPSE recommendations, the Individual Education Plans of twenty children, identified as speech and language impaired received speech and language therapy in the least restrictive environment, the classroom with typically developing peers. Initially, evidence supporting delivery of speech therapy through the pull-out model documented twenty-seven children. Throughout implementation twenty-three children were referred for evaluation. Three children were not identified as speech impaired. It must also be acknowledged that implementation took place during two program years. Hence the variation in enrollment and the number of children identified.

Outcome Six: The number of CPSE's to recommend that speech therapy be provided in an environment that was not isolated from other children, would increase from zero to three.

The number of CPSE's to recommend speech therapy in the least restrictive environment, the classroom, with typically developing peers rose from zero to two. The philosophy of the third committee remained driven by the notion that children with special needs require segregated placement. While not part of implementation, the committee serving the new expansion center, determined that a child with multiple concerns, including a language deficit, would remain in the Head Start program. In addition to language therapy, a support aide would be employed to help the child with routine activities. Clearly, this committee has already established an inclusion philosophy.

Outcome Seven: Each Head Start component plan would reflect how delivery of speech therapy was to be accomplished in classrooms.

Each of the five Head Start components, education, health, nutrition, social services, and parent involvement address how the Performance Standards are implemented. Every component, based on it's discipline, delineates how children with diverse abilities are served. As an outcome of implementation five Head Start component plans were changed to address inclusionary practices. The word mainstream was deleted throughout every plan. Job titles were changed from Special Education Coordinator and Mainstream Facilitator to Associate Education Coordinator and Support Aide, respectively.

In particular, the education plan was amended to reflect that speech and language therapy would occur in the least restrictive environment, the classroom,

with typically developing peers. Through amendments such as this, the primary goal of the education component, the development of social competence in young children is possible.

Other planned strategies, completed by the writer, involved activities intended to broaden the scope and implementation of inclusion. The following were accomplished by the writer: 1) attended a national conference focused on inclusion; 2) conducted a workshop on inclusion for a regional Head Start disabilities conference; 3) lectured to special education graduate students taking an Issues in Special Education class; 4) established a section of the program's library focused on inclusion; and 5) initiated contact with the preschool special education administrator to establish a working group for establishing a collaborative, integrated classroom.

Planned Strategy One: The entire focus of the week long conference was inclusion.

Nationally recognized leaders in the field discussed all of the issues that surround inclusion. The writer attended workshops related to the preschool population. Of particular interest were discussions about how the fields of education and special education were struggling with professional development. The information gathered by the writer helped to make the college presentation more robust.

Planned Strategy Two: Conducted a workshop on inclusion for a regional Head Start disabilities conference.

The writer received approval to conduct a two hour workshop on inclusion for parents at a Head Start conference on disabilities. Forty-eight parents were

registered. Thirty-two attended. Each of the parents had a child that was identified through the CPSE process has having a disability. The remainder of the group were Head Start staff and several speech therapists. There were a total of forty-three participants.

The writer presented an overview of inclusion through a historical perspective of how services to children with diverse abilities has evolved. From that point forward the presentation that had been planned was put aside because the parents had questions about their own situations. The writer used this forum to discuss inclusion. Content remained the same, only the delivery was changed to help the parents.

Planned Strategy Three: Lectured to special education graduate students taking an Issues in Special Education class.

Twenty-two special education graduate students received information about inclusion through a twenty-five minute summation report presented by the writer. This format was not anticipated. The structure of the class was changed from a lecture to a focus group approach. The students also completed a values clarification activity, once at the beginning of the class and then again at the end of the class. Table 2 presents the outcome of the values clarification activity from the graduate students.

TABLE 2

Values Clarification Results from Graduate Students

	Agree	Disagree
1. All programs, serving young children should be designed to include all children (children with differing abilities).	15	7
2. It is essential for all children to be socially competent.	15	7
3. Activities designed for typical children are often not appropriate for infants and young children with differing abilities.	11	11
4. All children have the same developmental needs.	11	11
5. I know about the federal and state laws related to special education.	15	7
6. Caregivers and service providers who do not have a background in special education can effectively work with infants and young children with differing abilities.	16	6
7. Children with mild disabilities are the best candidates for inclusion programs.	8	14
8. Young children with differing abilities can learn many important skills from each other.	21	1
9. The individual needs of infants and young children with differing abilities are best met within specialized programs designed for children with differing abilities.	5	17
10. I have less classroom control when therapists are part of the team.	2	20
11. It often seems easier to manage the room when a child pulled out for therapy.	2	20
12. There needs to more laws in order to make education accessible to all children.	11	11
13. The needs of children with moderate and severe differing abilities can be effectively met within an inclusion setting.	14	18
14. Adapting activities to include infants and young children with differing abilities should not be the responsibility of caregivers and service providers trained to work with typical children.	3	19
15. I have a lot of tolerance for modifying program routine and the classroom environments in order to meet the developmental needs of all children.	19	3

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Table 3 displays the distribution of changes. For nine students there were no changes.

TABLE 3

Summary Distribution of Changes		
change	>	2 students
changes	>	4 students
changes	>	3 students
changes	>	2 students
changes	>	2 students

> indicates greater support for inclusion

Discussion

Throughout this practicum, systemic change, as a template for inclusion has occurred through discrete events. When viewed cumulatively, the events, i.e. solution strategies, have addressed the multifarious issues of inclusion and the delivery of speech therapy within Head Start classrooms. Depending on one's perspective, the issues are either challenges or barriers. The glass is either half full or half empty.

Rose & Smith (1993) have identified six topics that are frequently associated as barriers to inclusion and integrated services for children with diverse abilities. The topics are: 1) attitude; 2) turf; 3) teacher preparedness; 4) awareness; 5) communication, collaboration, and respect; and 6) "someone will lose" issues, that is, a concern that an integrated class could have a negative effect on the services

all children receive. The solution strategies in this practicum have addressed each of the topics through a variety of approaches.

Prior to implementation of legislative mandates over the past several decades, educational opportunities for the majority of children with disabilities took place in segregated isolated environments that were perceived with negative collective identity. The classrooms were homogeneous and grouped by developmental age. Simulated environments with artificial achievement criteria frequently resulted in meaningless experiences that were presented as education.

While aspects of the above mentioned practices are still implemented, albeit with less frequency, the current trend and best practice is for children with diverse abilities to be educated in classrooms where they would be if there were no disability. Classrooms that are heterogeneous and grouped by chronological age, where natural criteria's, with minimal standards to succeed in real classroom environments are intended to promote functional skills and expand opportunities for meaningful socialization. Experiencing education through this approach allows children with disabilities to participate as normally as possible.

Clearly, the transition from one established approach to the creation of an alternative is not easy. It is viable however, when the substance of change, the process of change, and the organizational understanding of change is internalized and accompanied by active support and encouragement (Prestine & Bowen, 1993). The substance and process of the solution strategies implemented through this practicum was to create systemic change so that Head Start children identified as speech and language impaired would receive therapy in the least restrictive environment, the classroom, with typically developing peers. The integration of

speech and language therapy within the classroom environment provided children with the opportunity to "integrate, synthesize and organize their knowledge and skills across sequences of social exchanges in order to solve the diverse problems of a social nature typically encountered in daily life" (Guralnick, 1992, p.37).

The concept of least restrictive environment is predicated on the principle of normalization. That is, meeting a child's developmental needs through the regular system of education rather than through placement in a separate isolated environment. This approach emphasizes the similarity of needs rather than the differences of individuals with disabilities. Children with disabilities are more often than not, typical in some areas of development and thus capable of providing a model of appropriate behavior to typical children (Vincent, 1981).

Educationally, the principle of least restrictive environment is based on the philosophical premise that all children, including those with disabilities should be educated in a manner that does not inhibit their interaction with peers nor employ unusual instructional arrangements (Meyen & Lehr, 1980). It follows that because people develop differently it does not mean that development is governed by different process (Sarason & Doris, 1978) nor should education occur in a separate environment, particularly at the preschool age.

The typical preschool special education classroom is diagnostic and prescriptive. Curriculum content is approached from a deficit perspective. Objectives for remediation are usually taught in a didatic manner with specialized therapy conducted some place other than the classroom. In the least restrictive environment the curriculum is not tightly scripted. Children's developmental needs can be met through activities that motivate and challenge the child to use skills in a

variety of situations. The opportunity to generalize skills is greater in the least restrictive environments. Within the LRE teachers can "carpi diem" (seize the day or moment) and alter a well conceptualized basic curriculum in order to meet children's needs as well as situational exigencies (Allen, 1981).

The objective was to have speech and language therapy occur in five classrooms. To obtain the objective required collaboration with diverse populations reflecting a range of philosophies, professional experience, and regulatory mandates. The outcomes of the seven solution strategies were met with varying degrees of success. The cumulative result was that speech and language therapy began to be delivered in the least restrictive environment, the classroom, with typically developing peers. The number of Committees on Preschool Special Education to recommend the least restrictive environment increased from zero to two. In several instances district budget constraints rather than educational considerations guided decision making. However through this outcome, when it is questioned whether or not inclusive placement is best, results of previous CPSE recommendations could be used to support inclusion.

Public responsibility for preschool special education is relatively new. To break out of an established approach is not easy as school reform advocates will quickly point out. School reform and early intervention share common elements as noted by Strain & Smith (1991, p.2), "Not only is integration effective for children with disabilities but it is important to publicize the fact that the intervention procedures developed in early intervention and special education can offer huge dividends to schools interested in improving home-school collaboration, school survival skills, and a host of developmental outcomes for [all] children."

As has been documented through the literature a range of supports are necessary for inclusion to be successful. Elimination of the segregated therapy room and modification of component plans that now describe how support services, including speech therapy, will be implemented through inclusion are two outcomes effecting the ecology of the work environment.

Of all the areas through which change must occur, physical, social, and instructional, physical is the most easy. Through this practicum, physical modifications were accomplished with little difficulty. By eliminating the separate therapy room and creating communication learning centers, speech therapy had been integrated into classroom activities.

The outcome of the values clarification activity reflected favorable reaction to inclusion. The responses were indicative of a general acceptance of and belief that inclusion is a viable option. A comparison of responses between Head Start teachers and graduate students can be found in Table 4.

While the number in each group varied, a total of thirty-four participated. It was of interest to note that of the fifteen characteristics and values used to define inclusion, twelve in support of inclusion were identified by both groups.

Twenty-two agreed that they knew about federal and state laws related to specila education (item 5). However, eighteen agreed that more legislation was needed to make education accessible to all children (item 12). It is evident that there was not yet clear understanding of the comprehensive legislation that supports the inclusion of all children.

Fifteen agreed that all children have the same developmental needs (item 4). Nineteen disagreed. It is the opinion of the writer, that disagreement with this item

indicated a lack of knowledge about and recognition of the universal developmental needs of all children. Greater emphasis must be placed on development in order for all children to receive the benefits of inculsion.

Table 4

Comparison of Beliefs and Attitudes

Between Head Start Teachers and Special Education Graduate Students

	Head Start Teacher		Graduate Students	
	Agreed	Disagreed	Agreed	Disagreed
1.	11	1	15	7
2.	10	2	15	7
3.	8	4	11	11
4.	4	8	11	11
5.	7	5	15	7
6.	4	8	16	6
7.	7	5	8	14
8.	12	0	21	1
9.	3	9	5	17
10.	1	11	2	20
11.	0	12	2	20
12.	7	5	11	11
13.	7	5	4	18
14.	1	11	3	19
15.	10	2	19	3

Clearly inclusion, as a program option for children with diverse abilities, has to address a range of issues. To modify and manage the existing approach to special education is a complex task. Throughout this practicum systemic change has occurred through a variety of events that have unfolded to change the delivery of speech and language therapy from pull-out to inclusion. Successful outcome of solution strategies would not have been possible without collaboration, that is working jointly and cooperatively with others. The six concepts of collaboration

identified by Swan & Morgan (1993) were significant throughout implementation. The concepts include: 1) collaboration cannot be mandated; 2) collaboration is both a process and an attitude; 3) collaboration takes time; 4) collaboration does not develop evenly; 5) collaboration must be nurtured; and 6) collaboration must have clear goals.

While collaboration can not be mandated, educational services for children with diverse abilities have legislative mandates that make collaboration essential in meeting the comprehensive educational needs of all children. As a process and attitude, collaboration, through this practicum, indeed took time because of the variety of arenas in which the writer worked. From Head Start classrooms, to a college classroom, from parents to leaders in the special education field, and from preschool classrooms that fully include all children to segregated special education preschool classrooms, the writer had a range of forums through which to address inclusion issues.

Understanding inclusion ranged from not knowing anything about inclusion to those who are creating inclusion policy. This diversity of understanding allowed for and created a variety of goals, each contributing to some aspect of inclusion. As a result of the variety of stakeholder goals, some more clear than others, the writer, through the solution strategies created systemic change in the delivery of speech and language therapy. The knowledge acquired through this practicum will help the writer and the public school preschool administrator accomplish the goal of their initial meeting, that is to establish a collaborative classroom by September, 1994.

Establishing inclusive classrooms and creating systemic change is like baking an exquisite torte. The right ingredients, in the correct porportions, mixed

in the prescribed order, and baked at the proper temperature work in unision to produce a delicious dessert. Inclusion has it's own set of ingredients that , when combined in the right order, produce educational environments equally special for all children.

Implementing inclusion requires a paradigm shift away from exclusion and isolation toward heterogeneous, cooperative learning in integrated environments. It is unrealistic to think that inclusion is an approach that is universally appreciated and accepted. For many, inclusion is likened to a grain of sand in an oyster shell. At first it is an irritant. However, as layers upon layers of information are provided, the irritation recedes and is transformed into developmentally apopropriate educational practices that include all children.

Inclusion combines the best of early childhood education and early childhood special education. Inclusion unifies and strengthens existing resources. Inclusion builds respect for diversity. Inclusion is part of school reform. Inclusion is developmentally right for all children. Inclusion is "above all truly and simply a matter of will" (Center for Integrated Education, 1992).

Recommendations

The following recommendations are made as a result of the practicum outcomes:

1. Provide more teacher training on special education legislation so that there is clearer understanding of what has occurred and why.
2. One group of stakeholders missing from active involvement throughout the practicum was parents. As advocates for their children, parents need as much information about program options as possible. A parent support and information group needs to be established.
3. Teacher and parent training on the developmental needs of all children and stress social compentence.
4. Create an interagency committee to help with establishment of the collaborative classroom.

Dissemination

The writer, with colleagues from the Nova Cluster has submitted a workshop proposal for a statewide conference to be held in March, 1994. The conference title is: Celebrating Successes: Where We Are and Where We're Going. This is an interagency statewide conference on inclusive early childhood services. Should the proposal be accepted, a wide audience will have access to several practicum outcomes.

A training proposal will be submitted to the regional Head Start RAP conference. The writer will focus the content on systemic change, blessings and barriers. The target group will be Head Start staff responsible for children with diverse abilities.

Within the writer's immediate work environment the opportunity to disseminate knowledge gained through the practicum will occur through interagency staff meetings. As a member of the Local Early Intervention Coordinating Council (LEICC) the writer will have the opportunity to discuss inclusion with practioners who work with children with diverse abilities. This group of professionals and parents are part of the statewide network responsible for overseeing implementation of Public Law 99-457.

EPILOGUE

It is important to remember that children with_____benefit from the same environments that all children do; thus, designing classrooms appropriately for the child's develoopment is an important step toward managing the behavior of a child with_____. For young children this means a structured environment in which active involvement is an integral part of the learning process. In addition, tailoring work to fit the child's individual needs and encouraging collaboration and cooperation are practices recommended for all children with_____, as they are for all children.

Landaw, S. & McAninch, C.

Young Children, 48 (4), 49-58

RISK

You cannot discover new oceans unless you have the courage to lose sight of the shore.

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APPENDIX A

EDUCATION STAFF PROFILE

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EDUCATION STAFF PROFILE

Room 1	Education Background		Years in Progrm
Teacher A	BA	Elementary Education	4 months
Teacher B	HS/CDA High/Scope Lead Teacher (pending)	Child Development	4
Room 2			
Teacher A	HS/CDA High/Scope Lead Teacher (pending)	Child Development	9
Teacher B	HS CDA pending	Child Development	2
Room 3			
Teacher A	AA/CDA High/Scope Lead Teacher (pending)i	Child Development	8
Teacher B	HS/CDA High/Scope Lead Teacher Training	Child Development	26
Room 4			
Teacher A	BA High/Scope Lead Teacher	Elementary Education	6
Teacher B	HS/CDA High/Scope Lead Teacher (pending)	Child Development	3
Room 5			
Teacher A	BA	Elementary Education Master's Degree (pending)	2
Teacher B	BA High/Scope Lead Teacher (pending)	Elementary Education	2
Room 6			
Teacher A	BA High/Scope Lead Teacher (pending)	Elementary Education Master's Degree (pending)	2
Teacher B	BA	Elementary Education	4 months

*CDA - Child Development Associate - A certification to demonstrate competence in an early childhood classroom.

APPENDIX B

LIKERT SCALE

APPENDIX B

LIKERT SCALE

Attitudes/Beliefs About Inclusion

Prepared by Michele Strobridge
in partial fulfillment for the
Child and Youth Studies Doctoral Program
Nova University

Scoring Scale

Strongly Agree 1 2 3 4 5 Strongly Disagree

---

1. All programs, serving young children should be designed to include all children (children with differing abilities).
   1 2 3 4 5

2. It is essential for all children to be socially competent.
   1 2 3 4 5

3. Activities designed for typical children are often not appropriate for infants and young children with differing abilities.
   1 2 3 4 5

4. All children have the same developmental needs.
   1 2 3 4 5

5. I know about the federal and state laws related to special education.
   1 2 3 4 5

6. Caregivers and service providers who do not have a background in special education can effectively work with infants and young children with differing abilities.
   1 2 3 4 5

7. Children with mild disabilities are the best candidates for inclusion programs.
   1 2 3 4 5

8. Young children with differing abilities can learn many important skills from each other.
   1 2 3 4 5

9. The individual needs of infants and young children with differing abilities are best met within specialized programs designed for children with differing abilities.
   1 2 3 4 5

10. I have less classroom control when therapists are part of the team.
1 2 3 4 5

11. It often seems easier to manage the room when a child is pulled out for therapy.
1 2 3 4 5

12. There needs to be more laws in order to make education accessible to all children.
1 2 3 4 5

13. The needs of children with moderate and severe differing abilities can be effectively met within an inclusion setting.
1 2 3 4 5

14. Adapting activities to include infants and young children with differing abilities should not be the responsibility of caregivers and service providers trained to work with typical children.
1 2 3 4 5

15. I have a lot of tolerance for modifying programming, routine and the classroom environment in order to meet the developmental needs of all children.
1 2 3 4 5

APPENDIX C

NATIONAL PRESENTORS

APPENDIX C

NATIONAL PRESENTORS

Bruder, Marybeth, Ph.D., Director of Research and Early Intervention Program, University of Connecticut Medical Center

Cambell, Phillippa, Ph.D., Director of Human Resources Program, Temple University and President -elect for International Division for Early Childhood

Linder, Toni, Ph.D., Professor of Early Childhood special Education, University of Denver

Salisbury, Christine, Ph.D., Professor of Early Childhood Special Education, SUNY Binghamton and President, Division for Early Childhood

Swanson, Mark, M.D., Director of the University of Arkansas, University Affiliated Programs

APPENDIX D

HEAD START CONFERENCE

APPENDIX D

HEAD START CONFERENCE

Head Start Conference
Workshop Outline

Parents and Inclusion: The How's and Why's

I. Introduction

- self
- goals
- format

II. How did inclusion happen?

- brief history, use time line, 39 years of history from 1954 forward
- common elements
- parents have been there every step of the way

III. Why inclusion is the preferred classroom practice

- developmental issues
- differences do not define the child; a charateristic tells us one fact about the child

IV. Explain referral, evaluation, and CPSE meeting

V. Question and answers

APPENDIX E

INCLUSION PRESENTATION

APPENDIX E

INCLUSION PRESENTATION

Outline
Practicum II
Inclusion Presentation
Graduate Students
Issues in Special Education
In Partical Fulfillment of the Requirements
for the Degree of Doctor of Education

I. Values Clarification

II. Changing the paradigm

Inclusion - the newest model along the continua of services

- one liners about inclusion

  jello analogy - if you touch it in one place it makes the whole thing shake

  winds of change - Salisbury

- rationales for inclusion are based on philosophical, ethical, legal, values, historical and research

  > historical perspectives: nothing, private, public, separate, mainstream, pullout, integrated and inclusion

- biggest issue is implementation
- look at service delivery with graphics from Young Children 47, ladders and lattice
- define mainstream, pullout, integration and inclusion and level of service with each
- expand inclusion - organized service system to support children; a parental choice; collaborative team work;

III. Developmental Underpinnings

- Social
- Physical
- Instructional

-of the three, instructional has the most barriers

brainstorm why it has the most barriers: training, values, turf, fear-based on lack of knowledge, control issues, it is hard work to put theory into practice

IV. Do case study - if time allows

V. Summary Comments

- blueprint for inclusion has been drawn - as with all blueprints there are modifications and unanticipated events

- conference handout: Managing Complex Change related to vision, skills, incentives, resources, and action plan and the five outcomes when one of the keys is missing

VI. Close with puzzle

Prepared Michele Strobridge
in partial fulfillment of the
Child and Youth Studies Doctoral Program
Nova University

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Attitudes/Beliefs About Inclusion

Prepared by Michele Strobridge
in partial fulfillment for the
Child and Youth Studies Doctoral Program
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Scoring Scale

Strongly Agree 1 2 3 4 5 Strongly Disagree

---

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    1 2 3 4 5

Some adaptions from
Cordisco (1992)
Allegheny-Singer
Research Institute

Case Study

Directions: Construct a typical day with routine activities involving the child with special needs described below. Take into consideration all programmatic and physical accommodations necessary to assure that the child has equal opportunity to participate in all activities. Keep in mind the need to also involve the child in all areas of development, i.e. social, cognitive, language, gross and fine motor.

Linda is 4 years old and was born with cerebral palsy. She has some use of her arms and legs and can crawl slowly on the floor to get from one area to another. However, she primarily uses a wheelchair. She can feed herself but needs some assistance in keeping her head still and bringing the food to her mouth. She needs to be placed on the toilet and held there because her balance is poor. She appears to be bright and understands what is said to her. Though she is mostly non-verbal, she expresses herself through facial expressions, head nods for yes and no, eye movements and gross pointing. She is the youngest in the family with two older brothers. Both parents work and have recently transferred to this area. Jennifer had been in a special education class since she was nine months old receiving physical, occupational and speech therapies. Both parents are devoted to Linda and want her to continue receiving therapies in an integrated setting with children who are intellectually functioning on the same level.

Arrival/Breakfast/Transition to Work Time

Work Time

Large Group Activities - inside and out

Wash for lunch/lunch/quiet time before rest

Rest time and snack

Until children are picked-up Work Time, formal and informal activities